VOLUME 9 • NUMBER 2 • SPRING 2015 • www.jdpa.org

JDPA

Journal of Dermatology for Physician Assistants

THE SOCIETY FOR pediatric dermatology SINCE 1975

SUPPLEMENT
The Society for Pediatric Dermatology

Official Journal of the Society of Dermatology Physician Assistants

JDPA Journal of Dermatology for Physician Assistants

EDITORIAL MISSION: The JDPA is the official clinical journal of the Society of Dermatology Physician Assistants. The mission of the JDPA is to improve dermatological patient care by publishing the most innovative, timely, practice-proven educational information available for the physician assistant profession.

PUBLISHED CONTENT IN THE JDPA: Statements and opinions expressed in the articles and communications herein are those of the authors and not necessarily those of the Publisher or the Society of Dermatology Physician Assistants (SDPA). The Publisher and the SDPA disclaim any responsibility or liability for such material, including but not limited to any losses or other damage incurred by readers in reliance on such content. Neither Publisher nor SDPA verify any claims or other information appearing in any of the advertisements contained in the publication and cannot take responsibility for any losses or other damage incurred by readers in reliance on thereon. Neither Publisher nor SDPA guarantees, warrants, or endorses any product or service advertised in this publication, nor do they guaranty any claim made by the manufacturer of such product or service.

THIS ISSUE: The JDPA includes articles that have been reviewed and approved for Category I (Preapproved) CME credit by the American Academy of Physician Assistants. Approval is valid for 1 year from the issue date, and participants may submit the self-assessment at any time during that period. Category I CME articles included in JDPA are planned and developed in accordance with AAPA's CME Standards for Journal Articles and for Commercial Support of Journal Articles.

GOING GREEN: Since its inception, the JDPA has utilized eco-friendly printing practices. The JDPA is printed on paper obtained from sustainable forests that meet strict environmental standards. Soy-based inks that have a low environmental impact are used during printing of the journal and the journal is printed using 100% renewable energy. SDPA members may join us in our efforts and opt to receive the JDPA in digital format.

PUBLISHING STAFF

Publisher Travis Hayden, MPAS, PA-C
Managing Editor Jennifer M. Hayden, M.Ed
Copy Editor Douglas Morris
Art Director Angela Simiele
Website Design Terry Scanlon

SALES OFFICE

Physician Assistant Communications, LLC
P.O. Box 416, Manlius NY 13104-0416
Phone (315) 663-4147
PAC@pacommunications.org
www.pacommunications.org

KEEP CURRENT WITH THE SDPA:

JDPA.org

JDPA/Journal of Dermatology for Physician Assistants (ISSN 1938-9574) is published quarterly (4 issues per volume, one volume per year) by Physician Assistant Communications, LLC, P.O. Box 416, Manlius NY 13104-0416. Volume 9, Number 2, Spring 2015. One year subscription rates: $40 in the United States and Possessions. Single copies (prepaid only): $10 in the United States (Include $6.50 per order plus $2 per additional copy for US postage and handling). Periodicals postage rate paid at New York, NY 10001 and additional mailing offices.

POSTMASTER: Send address changes to Society of Dermatology Physician Assistants, Inc., 4111 W. Alameda Ave. Suite 412, Burbank, CA 91505, 1-800-380-3992., email SDPA@dermpa.org, www.dermpa.org.

From The Patient's Perspective

Hair Dyes, Cosmetic Cream Preservatives, and Hip Replacements

By Mrs. Helen

THE SOCIETY FOR pediatric dermatology SINCE 1975

The Society for Pediatric Dermatology's (SPD) objective is to promote, develop, and advance education, research, and care of skin disease in all pediatric age groups. The organization holds meetings twice a year to educate physicians about advances in pediatric dermatology, help them support children with dermatological diseases, and improve the care of these children.

Society for Pediatric Dermatology
Contact Information: www.pedsderm.net
8365 Keystone Crossing, Suite 107,
Indianapolis, IN 46240
Email: info@pedsderm.net
Phone: (317) 202-0224

Allergens causing clinically relevant allergic contact dermatitis in adults in the US are important in children as well. Notably, there is a significant lack of published studies performed on US children. That is why the Society for Pediatric Dermatology is supporting the Loma Linda University launch of its "Pediatric Contact Dermatitis Registry" initiative, which has two specific components:

1) A brief 'click through' provider registry/survey, which records the demographics of the clinical provider offering patch test services to children, available at:
http://lomalindahealth.org/medical-center/our-services/dermatology/for-health-care-professionals/practitioner-database-registration-form.page

2) An entirely optional case log component, which any registered provider can voluntarily record his/her cases on a provided short reporting form into the database.

The purpose of collecting this data is to:

- Increase the number of verified cases of contact dermatitis in children ages 0-18 years in the US.
- Promote awareness of contact dermatitis in pediatric populations.
- Shed light on the demographics of providers offering pediatric patch test services.
- Help to highlight regional disparities in access to patch test care and evaluation for children.

Accurately representing the key role of PAs involved with providing patch testing services is paramount. Please help and take the brief survey today. Thank you.

I have had sensitive skin and allergies all my life and have taken allergy medication and shots. I experienced eczema and even had numerous skin cancers removed. To top it off, I am a breast cancer survivor of thirteen years, so I have had my share of medical issues to deal with in my fifty-seven years. Nothing, however, prepared me for the experience I would be thrust into in February 2003. I was prescribed a well-known statin drug, and after a few days of taking it my face began to itch and rash. On the fifth day I woke up looking like a monster with a bright red, swollen, and indescribably itchy face. I called the office where I had been prescribed the medication and was informed they could not fit me in. I informed them that I was indeed "coming in," and when they saw my face I was sure that they would see me right away. When the medical assistant slid open the glass door into the patient waiting room, his eyes widened in disbelief with a hint of horror; a look I was to see many times over in the next few years from those who witnessed me during a major flare-up or saw my "show and tell" photos that I took to all of my appointments for the next two years. The doctor gave me a shot of cortisone and a prescription for a prednisone dosepack. Over the next few days, thanks to steroids, the red, swollen, and itchy skin was replaced by parched skin that had the consistency of sandpaper and then miraculously turned into clear, fresh dewy looking smooth skin.

Thus began a two-year sentence of tortuous skin eruptions and an emotional roller coaster ride. I experienced severe flare-ups, often several times a week. The flare-ups would begin with an itchy face and very rough skin. Then the skin would begin to feel raw and burned, and most ointments or creams felt like pouring alcohol on an open wound. The next phase that followed was peeling, parchment-dry, sandpaper like skin that no cream, moisturizer, or diaper ointment alleviated. One dermatologist prescribed a soothing mask of fresh cold yogurt followed by Crisco, which provided short-term relief. Several times I was given antibiotics when the inflamed skin became secondarily infected. Despite vast quantities of Benadryl, prescription antihistamines, and creams, nothing helped except the systemic steroids.

I began my long journey seeking help within the medical community, first seeing my allergist. After

seeing my inflamed face, sometimes with bright red circles around my eyes several times, the doctor diagnosed "allergic contact dermatitis" or ACD, not hives as I had assumed. This was my first introduction to the name of this hideous disease. By March, I had seen my dermatologist and allergist several times and found an endocrinologist, who after many tests, told me I had a compromised immune system, a sluggish adrenal system, and was possibly pre-auto-immune though I did not test positive for it. He put me on a daily regimen of 10mg of prednisone for the next three months and told me it was dangerous to be on it any longer than that and that the prednisone would make me gain weight (how true!).

"People like me with chemical allergies have sometimes been referred to as this century's canaries… Perhaps it is time to heed the warnings of the canaries!"

After I was off the prednisone for the appropriate time, my allergist ordered a T.R.U.E. Test® (allergen patch test) to be performed, which yielded no results! Perhaps this was because a medical assistant, uneducated in proper patch test reading techniques and protocol, had administered the test. I was never told to come back for a final reading on Friday, after the assistant removed the patches on Wednesday and saw no reactions. I was still in the dark about what was causing my flare-ups, which continued week after week.

I never knew when I accepted a social invitation, if I would really be able to attend. I missed numerous days at work, hiding my face at home during a flare-up or going to doctors' appointments. After many months, I let more and more friends and colleagues see me during a flare-up. Often I would burst into tears upon waking up in a full fledged flare-up, knowing the impending cycle to come over the next four or five days.

My second allergist also administered a T.R.U.E. Test® in August 2003 and discovered I was very reactive to a common preservative, methylchloroisothiazolinone/methylisothiazolinone (MCI/MI). Knowing I was highly allergic to MCI/MI was a big help, as I could begin to examine everything in my medicine cabinet and extensive arsenal of makeup, hair, and skin products. I eliminated products and carefully scrutinized all product labels before buying. I read the long list of ingredients on products looking for MCI/MI or synonyms for it.

Sounds fairly simple, but not so fast! I had begun to notice that every time I went on a business trip and stayed in a hotel, I started to flare up by the second or third day. The dreaded itchy rash returned on my face often accompanied by swollen eyes, a portent of a full flare-up to come. I carried "melt in your mouth" children's Benadryl and would copiously pop them in my mouth at the first sign of trouble, to no avail. I carried tinted glasses, so when my eyes began to swell I could cover them up and still help work the vendor booth for the company I partially own. When the flare-up was really bad, I would often call a doctor to get a prescription for a steroid dose pack to alleviate the problem and allow me to finish the trip without a major flare-up occurring. Then in August of 2003, we bought a vacation condo. The realtor left a big basket of cleaning products, which included liquid fabric softener, something I do not use at home. Lo and behold, after two nights sleeping on the sheets and pillowcases, I began a flare-up. This was one of the countless times I racked my brain to figure out what I was using that was "different" or "new" and the liquid fabric softener light bulb lit up! I discovered by trial and error and my own amateur investigative work that MCI/MI is in most liquid fabric softeners and some liquid soaps. The ingredients are not listed on these products for competitive purposes.

It was then I discovered that finding product ingredients when they are not listed on the product is not a simple task. The ingredients are not on company web sites and you must put in a request, either in writing or by email and eventually be contacted. You will not be provided with a list of ingredients, but will be told if indeed the substance you ask about is in the product. MCI/MI is in liquid fabric softeners (not sheets) from the three major manufacturers that I checked with. This is typical of the sleuth work that the patient must go through to eliminate any known allergen!

Over eighteen agonizing months, I saw six dermatologists, three allergists and continued to see my endocrinologist searching for answers. I spent thousands of dollars on my portion of numerous medical tests, untold amounts of creams, OTC medications or supplements, acupuncture, products and devices, including an electric hand-held anti-itch device ordered from the Internet. Amazingly, the anti-itch device for $49.99 actually did provide some temporary relief! I switched to organic pest control in my house in an attempt to rid my life of unnecessary chemicals, and began eating organic food whenever possible. I went to a medical intuitive who told me my adrenal system was

not working well but gave no good path to recovery. I even tried drinking fresh aloe to cleanse my immune system. At this point, if someone told me rubbing monkey dung on my face would solve the problem, I would have tried this too!

I was on systemic corticosteroids for a three-month period in 2003, a one-month period in 2004, and had at least three cortisone shots and many dose packs along the way. I vaguely knew they had a potential to be dangerous, but desperation and agony usually preceded my requests for this relief. I also knew people with asthma took prednisone for years.

At some point during my odyssey, I realized via my internet research that I needed extended patch testing. First I started asking the allergists and the six dermatologists, including one at the Cleveland Clinic, hoping they could either administer the extended patch test, or would know someone (anywhere!) who did. Nada! One allergist had provided the name of a doctor in New York City, whom I was unable to contact. After several months, I printed out a long list of local Miami dermatologists from my insurance company web site and began phoning to ask if they performed extended patch testing. Most of the appointment schedulers did not have a clue as to what I was talking about, and I usually had to hold for a nurse, or be called back. Many phone calls later; I eventually hit pay dirt when I called the University of Miami Dermatology Group. The scheduler happened to ask a nurse in the presence of a resident. I was given the name of Bruce Brod, MD, at the University of Pennsylvania. This contact became vital to my eventual diagnosis.

Coincidentally, or by the grace of God, I had a vendor show coming up in Philadelphia three weeks after getting Dr. Brod's name. It is amazing what begging can do. The scheduler actually took pity on me when I told her my situation and fit me in to see Dr. Brod in May 2004, a full fifteen months after my first severe flare up.

In Philadelphia, Dr. Brod was very compassionate, saying I must get help as my quality of life was suffering. What an understatement, but at last I had found someone who truly related to my plight! Dr. Brod said he could perform tests in Philadelphia, but I might be more interested in a physician on the west coast of Florida, Anthony Fransway, MD. Fransway was not taking new patients, so the necessary referral paperwork was administered and I eventually got a blessed appointment for August 4th, 2004 in Ft. Myers, Florida.

On a Monday eighteen months after my first severe flare-up, Dr. Fransway administered an extended patch test and 206 ingredients were positioned on my back next to identifying numbers and covered with tape. I could not get my back wet for the five-day test duration. On Wednesday, the patches were removed for the first reading and I returned Friday for the second reading. Finally! I was given an extensive list of allergens and directions for following an "avoidance" regimen. My allergens included bacitracin, gold-sodium-thiosulfate (gold), nickel, fragrance mixture, methylchloroisothiazolinone/methylisothiazolinone (MCI/MI), bromo-nitropropane diol, paraphenylenediamine mix (PPD), and dermatophagoides (dust mites). Later, tetracaine, 2,5-diaminotoluene sulfate, and ammonium persulfate would be added to this list. Gone was my gold jewelry (replaced by platinum, silver, or stainless steel tested for nickel content). No more hair color, as hair dye contains PPD, one of my major allergens. I changed many personal products including my laundry detergent, my toothpaste, and looked for "fragrance free" products that did not contain my allergens. The flare-ups did not entirely go away, but subsided immensely! On a follow up visit to Dr. Fransway, several months later, I gave Fransway a big hug, telling him he had given me my life back!

My sixth dermatologist informed me in December 2004 that thankfully, Miami now had a dermatologist specializing in allergic contact dermatitis! This was my introduction to Sharon Jacob, MD, Assistant Professor of Clinical Dermatology at the University of Miami, who has been so important in my diagnosis, education, and understanding of allergic contact dermatitis. Ironically, that resident in clinic who directed me to Dr. Brod in the first place had been Dr. Jacob. A marvelous touch of fate provided the help I so desperately needed. Through Dr. Jacob, I am still learning new ways to avoid allergens each and every day. I learned additional products to avoid. I learned I needed to purge all products from my life that were not "fragrance free." I had not been strict about "fragrance free," and consequently when I got serious, I eliminated a large shopping bag full of products from my home. I learned the term "unscented" means yet another chemical has been added to the product to mask the scent. Read product labels and you will see chemicals upon chemicals upon chemicals.

Dr. Jacob also sternly warned me about the dangers of over-use of steroids, as I still had big flare ups when I stayed in hotels and had a prescription for a few more dose packs that I would use in desperation. Sadly Dr. Jocob's warning came too late! I started having right leg pain around the middle of January 2005. I had just taken a yoga class, so I attributed the pain to a pulled muscle or tendon. The pain worsened, causing me to limp part of the time and to have pain every morning.

I saw two orthopedics in the beginning of February and one began the process of x-rays, bone scans, and MRI's. By the beginning of March, I was also having pain on my left side, walking with a cane, in lots of pain at night and severe pain in the morning. I still attributed this to a soft tissue injury, and went into major shock when I was given my diagnosis in mid March 2005.

My diagnosis - bilateral osteonecrosis or avascular necrosis. Loss of blood supply to the bone or increased pressure within the bone causes the blood vessels to narrow; making it hard for the vessels to deliver enough blood to the bone cells and the bone literally necroses or dies. The probable cause - off and on systemic corticosteroid use for a two-year period. My treatment - complete hip replacement or hip decompression surgery for both hips!

I am now using crutches or painfully lurching around on a walker and seeking the best orthopedic surgeon to perform my needed surgery and treatment. When the pain is not too bad, I work on the computer from my house, as going into the office is difficult. Friends take me grocery shopping and my over-stressed husband is trying to run a business and take care of chores he never even dreamed of in the past. In the 19th century, miners carried canaries in small wooden cages down into the mines. The little garden-variety songbirds served as sentinels for miners, warning them by dying or falling off their perch when toxic fumes were in the mineshaft. The cheerful birds were extra sensitive to poisonous gases, so they'd react to them well before the miners, who would then quickly evacuate. People like me with chemical allergies have sometimes been referred to as this century's canaries. What is the proliferation of chemical additives in foods and products doing to our children, our environment, and ourselves? Perhaps it is time to heed the warnings of the canaries!

My current orthopedic condition was avoidable and is a human medical tragedy I will have to make the best of. I am telling my story to prevent someone else from going through what I have, and what I face in the next year. There is a serious lack of education regarding allergic contact dermatitis by lay people, doctors, and medical personnel. There is a serious lack of knowledge of the side effects of systemic corticosteroids too. And finally, there is a major lack of access to the patch testing modality. Had the majority of my allergens been diagnosed within the first six months, I would not have taken steroids for two years and would not be facing extensive surgery and orthopedic treatment. This did not need to happen to me and should not happen to anyone else.

Take Home Points for Derm PAs:

By Steven K. Shama, MD, MPH, FAAD

Helen has made two points: better education about contact dermatitis and the skills involved in patch testing.

1. The author clearly suffered from what many of us in the contact dermatitis field see as avoidable. There is no doubt that not enough of us in the field of contact dermatitis are educating clinicians in specialties other than dermatology about what a contact dermatitis looks like and what can be done to sort out the specific causes.

Even with our own dermatologic colleagues, it is truly unfortunate how many are limited in experience, specific knowledge, and interest. We as clinicians in dermatology must lay claim to this subspecialty and either do it "the right way" or refer to an experienced colleague. Those of us who perform patch tests on a regular basis must make ourselves more available.

2. The side effects of systemic corticosteroids are often silent until… We have in this patient's story an ending that might have been different had a patch test specialist been involved soon after the first course of prednisone was administered. It is this writer's humble opinion that in some instances of chronic itchy eruptions, multiple courses of prednisone are given "innocently," without true appreciation of the harm that it might be doing.

It is "easy" to administer a short course of prednisone and then repeat it in a month or two and then bimonthly, without realizing that multiple short courses of high dose prednisone may have similar side effects (at least in regard to joint concerns) to a one long course of low dose. Beware of prescribing prednisone anytime, but especially whenever the diagnosis is in doubt and especially when you prescribe that second course for the same diagnosis.

Dermatology Physician Assistants

Physician Assistants (PAs) in dermatology play a number of varied and vital roles.

PAs are medical providers licensed to practice medicine with physician supervision. From patient care and education, to skin surgery, treatment of chronic skin conditions, and cosmetic procedures, PAs are dynamic members of the healthcare team. PAs practice in every medical and surgical specialty and have been collaborating with dermatologists for 30 years, providing a wide variety of services. These include diagnosing, prescribing medications, ordering and interpreting lab tests, wound suturing, and medical or surgical treatment of a wide variety of clinical diseases. As with all PAs, dermatology PAs are legally and ethically bound to practice only under physician supervision.

PAs are trained in intensive, accredited education programs.

Because of the close working relationship that PAs have with physicians, PAs are educated in the medical model designed to mirror and complement physician training. PAs take a national certification examination and to maintain their certification, they must complete 100 hours of continuing medical education every two years and take a recertification exam every six years. Graduation from an accredited PA program and passage of the national certifying exam are required for state licensure.

How a PA practices dermatology varies with training, experience, and state law. In addition, the scope of the PA's responsibilities corresponds to the supervising physician's scope of practice. In general, a PA will see many of the same types of patients as the physician. Referral to the physician, or close consultation between the PA and physician, is based on the dynamic relationship between the physician and PA.

The Society of Dermatology Physician Assistants (SDPA) is a non-profit professional organization, composed of members who provide dermatologic care or have an interest in the medical specialty of dermatology. Fellow members provide medical services under the supervision of a board certified dermatologist.

More information can be found at **www.dermpa.org** and **www.aapa.org**.